LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV MEETING MINUTES
November 13, 2008

MEMBERS PRESENT	MEMBERS PRESENT, cont.	PUBLIC	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Angélica Palmeros	Marcos Aviles	Kyle Baker
Anthony Braswell, *Co-Chair*	Natalie Sanchez	Sergio Aviña	Maxine Franklin
Al Ballesteros	Robert Sotomayor	Robert Butler	Michael Green
Anthony Bongiorno	Kathy Watt	David Crain	Carlos Vega-Matos
Mario Chavez/Terry Goddard	Fariba Younai	Camila Crespo	Lanet Williams
Eric Daar		Marc Davis	Juhua Wu
Nettie DeAugustine		Thanh Doan	
Whitney Engeran-Cordova	**MEMBERS ABSENT**	Jesus Gaspar	
Douglas Frye	Carrie Broadus	Miki Jackson	**COMMISSION STAFF/CONSULTANTS**
David Giugni	Richard Hamilton	Jenny O'Malley	
Jeffrey Goodman	Everardo Orozco	Jose Paredes	Julie Cross
Joanne Granai	Mario Pérez	Cecilia Rosales	Carolyn Echols-Watson
Michael Johnson	James Skinner	Julian Sanchez	Dawn McClendon
Lee Kochems	Peg Taylor	Jay Villarreal	Jane Nachazel
Brad Land	Chris Villa		Glenda Pinney
Ted Liso			Doris Reed
Anna Long		**SPN COORDINATORS**	James Stewart
Manuel Negrete		*(Non-Commission Members)*	Craig Vincent-Jones
Ruel Nolledo		Gabriela León	Nicole Werner
Quentin O'Brien		Jane Price-Wallace	
Dean Page		Jill Rotenberg	

1. **REGISTRATION/WELCOME**:

2. **CALL TO ORDER**: Mr. Braswell called the meeting to order at 9:00 am.
   A. Roll Call (Present): Ballesteros, Bongiorno, Braswell, Daar, DeAugustine, Engeran-Cordova, Frye, Giugni, Goddard, Goodman, Johnson, Land, Liso, Long, Negrete, Nolledo, O'Brien, Page, Palmeros, Sanchez, Sotomayor, Watt, Younai

3. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order ***(Passed by Consensus)***.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED**:
   - Mr. Johnson, Consumer Caucus Co-Chair, thanked Ms. Franklin and Dr. Davis for their support and encouragement to serve.
   - The Consumer Caucus and consumers of the County accomplished a great deal this past year. They acknowledge the help they received in developing a new way of meeting consumer needs. On their behalf, Mr. Johnson presented plaques to Mr.

Vincent-Jones for meeting with consumers, understanding their needs, and helping get the Consumer Caucus off the ground; and Dr. Green who has worked to address consumer needs including Medicare Part D Gap Assistance. The inscription reads, "In recognition for your outstanding work and commitment to meeting the needs of those living with HIV and AIDS with deepest appreciation and thanks, Los Angeles County Consumers."

- Mr. Vincent-Jones thanked consumers for honoring him. He felt greater consumer ownership and participation would benefit both the County as a whole and the Ryan White Administrative Mechanism.

6. REVIEW OF ACCOMPLISHMENTS: Mr. Braswell reviewed the accomplishments of each committee over the past year.

7. CO-CHAIRS' REPORT:

A. Member Nominations: Mr. Butler was on the Commission previously as Co-Chair of the Recruitment, Diversity, and Bylaws Committee, precursor to the Operations Committee.
MOTION #2: Nominate Robert Butler to the SPA #8 Consumer seat and forward to the Board of Supervisors for appointment to the Commission ***(Passed by Consensus)***.

B. Co-Chair Nominations: Ms. Bailey opened Co-Chair nominations. She re-nominated Mr. Braswell to continue in the office. Other nominations will be accepted until the election at the December Commission meeting.

8. MEDICARE PART B:

A. Medicare Part B Premium Payments:

- Ms. Cross noted eliminating the benefit during budget cuts went through with little discussion especially as California was one of only two states that have offered the option. The Office of AIDS (OA) was reviewing how they might help.
- Mr. Braswell stressed the importance of encouraging everyone including provider and consumer networks to help ensure consumers know the consequences of dropping coverage and options for help. The Commission has already released one Policy Brief and will provide follow-ups as information becomes available.
- Ms. Cross noted premiums had previously been covered seamlessly, so those receiving a reduced Social Security or retirement check could be confused, especially as Medi-Cal and Social Security notices have not been very informative. Individuals' situations vary, e.g., those whose coverage was assigned to an HMO could lose their entire HMO coverage.
- There are 350 to 400 PWH/A in the County. Medi-Cal has estimated 57,000 to 88,000 will be impacted statewide.
- Mr. Butler noted there was a Working Disabled Program that could reduce the Medicare share-of-cost up to 250%. Ms. Cross clarified that the program shifted people from a monthly share-of-cost to a premium which can be less expensive. She noted Medi-Cal has become stricter with applications, so those interested should maintain good records.
- Ms. Cross said Medi-Cal had paid premiums through a technical contract data exchange with Social Security not available to outside entities. She had been reviewing EMA approaches like using the Part D Gap Assistance Program. She was also working with the Department of Health Care Services and the National Senior Citizens Law Center.
- Mr. Vincent-Jones estimated a maximum monthly cost of $40,000 for a $96.40 for 400 PWH/A through Year 18. The Executive Committee limited the coverage period to acknowledge potential Year 19 award changes and OA actions. He noted funds were available from the underutilized Medicare Part D Gap Assistance Program and HRSA had okayed use of Part A funds for this purpose.
- Mr. Engeran-Cordova, while in favor of the motion, cautioned this was the second time the EMA would cover a gap in another service. Others may consider it a precedent, so such situations needed to be watched closely.
- Mr. Vincent-Jones clarified that the Executive Committee acted for the Commission on emergency basis only, so a Commission vote was not needed, although the Commission's ratifications of the Executive Committee's action was appropriate.

➲ It was agreed to refer Medicare Part D Gap Assistance Program extension to the Priorities and Planning Committee.

MOTION #3: Ratify the Executive Committee decision to allocate Part A funds, as necessary, to pay for Medicare Part B premiums through Year 18 ***(Passed by Consensus)***.

9. STATE BUDGET:

- Mr. Kochems called attention to summaries of proposed state special session budget cuts in the packet and from APLA.
- Ms. DeAugustine, City of Long Beach, noted they were notified almost daily of additional cuts to a broad range of services like TB, dental services, and maternal health. Federal and state agencies themselves are having difficulty keeping informed.
- Ms. Watt noted social pressures like the passage of Proposition 8 and the economy had pushed up requests for services with even previously sober people calling for help just as resources were shrinking.
- Dr. Green reported OAPP had had the Early Intervention Program (EIP) cut $358,000 retroactive to 7/01/2008 though funds have been expended since then. Ms. DeAugustine noted a $40,000 EIP cut for Long Beach in addition to a previous 10% cut.

- Mr. Nolledo reported the Governor was meeting with Democratic and Republican leaders, and a press conference was expected 11/20/2008. The Legislature can vote no later than 11/23/2008 for this session. Meanwhile, advocacy actions were being planned by several health and education coalitions including a call-in day for legislators.
- Mr. Braswell noted the EMA has traditionally had the best care and will have to be judicious in the new economic climate. Some support services that have been provided may need to be phased out to maintain critical services.

➲ It was agreed to try and call a special Consumer Caucus meeting on the budget.

10. COMPREHENSIVE CARE PLAN (CCP):

A. Introduction: Mr. Goodman and Ms. Watt provided an overview of the draft being presented for public comment. Required every three years, this version of the CCP must be submitted to HRSA by 12/31/2008. The four questions it must answer are: Where Are We Now? Where Do We Need to Go? How Will We Get There? How Will We Monitor Our Progress?

B. Face of AIDS: Dr. Long explained profiles were composites based on a wide range of data to provide a sense of the special populations served with an emphasis on their needs and concerns.

C. CCP Accomplishments: Mr. Braswell and Ms. Bailey reviewed work accomplished on the ten 2005 CCP goals: health outcomes, service responsiveness, service integration, service delivery, collaboration, quality of care, cost efficiency, leadership development, service effectiveness, and barriers. This work represented a solid foundation to move forward despite deteriorating economic conditions since 2005.

D. Epidemiology Profile:

- Dr. Frye announced that over 13,000 cases of HIV and 4,000 of AIDS have been reported to date since the start of name-based reporting. The strong numbers may mean that name-based cases might be used even if Ryan White is extended.
- The database is not yet stable, so only estimates are available. These remain at about 64,000 PWH/A in the County. Of those, 23,000 are PWA, 15,000 are estimated to be aware of their HIV status and not in care, and 16,000 are estimated to be unaware of their HIV status.
- Male cases predominate with percentages in the high 80s, but female cases are trending up based on 2006/2007 reported cases. Latino AIDS incidence leads at 42.7% yet, based on the population, this appears to indicate under-reporting. AIDS incidence is highest among those 25-49 at 77.7%, but AIDS prevalence nearly doubles to 32.9% among those over 50 with repercussions for medical care. SPA variations have remained stable.
- Some special populations lack adequate studies for viable estimates. There is little information available on sex workers, e.g., and no one has done surveillance on the deaf/hearing impaired and the blind/sight impaired though behavioral studies indicate access and information issues. Persistent mental illness estimates are being developed. The highest HIV prevalence special populations are: African-American MSM, 32%; Transgender Women and American Indian MSM, both at 21%; and Latino MSM, 16%.
- Prevalence rates for women were not yet in the slides, but Dr. Frye related key data. Monolingual Spanish-speaking data was not yet available. Other prevalence rates were: all ages, 0.1%; 25-49, 0.2% (8.5% of the epidemic); women at risk (all risk factors), 2.1% (11.4% of the epidemic); at risk women of color, 9.3%; at risk African-American women, 6.3%.

E. Consumer Needs Assessment:

- Ms. Pinney reviewed the Los Angeles Coordinated HIV Needs Assessment (LACHNA) developed jointly in 2007 by the Commission, the Prevention Planning Committee (PPC), and OAPP. It was revised in 2008 to include questions on service barriers and effectiveness. The 2008 data was still being analyzed, but would be included in the CCP.
- Recruitment was countywide, but the majority of respondents from both years who identified a residence lived in SPA #4. In 2007, the highest proportions of respondents were male (76.52%), MSM (52.7%), and Latino (51.65%).
- Responses were only included from those without private health insurance, but receiving HIV/AIDS medical care. Respondents were queried about all 39 service categories grouped into clusters: medical, primary health, access, coordination, counseling/education, barriers, and residential. Some categories were broken down further to elicit detailed information like the relative need, awareness, and use of bus passes, bus tokens, and taxi vouchers under transportation.
- Service awareness, need, receipt, and gaps were analyzed for total respondents; males, females, and trangender people; African-Americans, Latinos, and whites. Asian/Pacific Islander and Native American data was insufficient for analysis.
- The average service gap was lowest among monolingual Spanish-speaking respondents. It was highest among youth followed by sex workers who also had the broadest range of gaps among services.
- Of the total 829 people surveyed, 48 said they had not seen a physician since diagnosis. An additional 265 people said they had returned to care in the last six months after having been out of care for at least twelve months. Both of those groups which represent unmet need were mostly male, Latino, and 25-49.
- Mr. Vincent-Jones affirmed that eventually populations will be compared over time. Definitions have posed a problem because they have not remained stable over time. Also, HRSA, PPC, OAPP, and Commission definitions have often been different from one another for various reasons. Defining special populations and developing a joint needs assessment are means of addressing that problem. Beyond improving the ability to perform statistical analysis, the

Continuum of Care framework will allow data to be plugged in to analyze how people are actually moving through the service system.

- While oral health remains the top need, Mr. Vincent-Jones noted funding had almost doubled over the past four years. Services have been increased gradually to allow providers time to increase their capacity.
- Mr. Braswell noted some of the second or third ranked service needs, like housing, mental health, and substance abuse services, were among those that may be at risk as funding tightens. Loss of those could impact primary care.
- Mr. Butler said many with private medical care have difficulty accessing supportive services through Medical Case Managers. Mr. Vincent-Jones replied that Medical Care Coordination was not yet implemented, but would address that.
- Conclusions will be drafted for the CCP after the second round of LACHNA data was incorporated.
- ➲ Dr. Younai noted the five oral health questions added a couple of years ago were validated questions already used in national studies, so could be used for comparative analysis. It was agreed to include them in the CCP.

F. Community Resources Inventory:

- Mr. Vincent-Jones discussed the importance of three structural indicators to the system of care: resources, provider capacity, and provider capability. The CCP will address these primarily with mapping and data being developed in the future.
- Resources come in a variety of forms, but key focus areas are agency resources and their funding sources, including other funding streams. While the latter have been addressed informally to date, they will warrant more attention going forward.
- An agency resource inventory allows evaluation of service availability including resources not funded by Ryan White. Eventually, availability can be mapped to compare availability with need.

G. Provider Capacity/Capability:

- Capacity evaluates what the system can absorb. It highlights gaps where need exceeds availability as well as excess capacity. The financial model being developed for the CCP will measure perceived and actual gaps against contracted services, if contracted services are being delivered, and if standards of care expectations are realistic and being met.
- Capability evaluates the quality of that care, e.g., do providers have the skills to meet expectations. OAPP has developed a quality management method to assess provider capacity for the CCP and are developing one for provider capability.
- Mr. Land noted consumer service rankings can be influenced by gratitude for recently received services, anxiety over those currently lacking, and consequent changes over time. He asked how to accommodate that in financial modeling.
- Mr. Vincent-Jones said financial models depend on quantitative data weighted on assumptions informed by qualitative data. A qualitative survey was done after the 2007 LACHNA. This year finances and timing limited it to information from focus forums and "Meet the Grantee" meetings. The goal is to fully develop both the quantitative data and qualitative surveys with each informing the other.
- ➲ It was agreed to include the role of the Consumer Caucus in the CCP.

H. Barriers to Care:

- Ms. Pinney noted questions on barriers and their importance in accessing services were added to LACHNA in 2008.
- Barriers are categorized by structural issues like rules and regulations; organizational issues like provider sensitivity and expertise; and individual issues like an individual's knowledge, ability, and sense of well-being.
- Most LACHNA respondents did not report access problems, but analysis of the data is ongoing.
- Ms. Sanchez and Ms. Granai reported on focus forums in the eight SPAs to elicit provider perceptions of barriers.
- Some populations are more impacted, e.g., documenting residency can be a particular structural barrier for the homeless or those new to the country. Likewise, the emphasis on making appointments by phone can be a daunting organizational barrier for those without a callback number or those unable to access information in Spanish. Provider sensitivity to diverse populations like youth or trangendered people can be another form of organizational barrier.
- Other barriers cut across populations, e.g., an organizational barrier is created when information is not shared with a patient that affects eligibility for services, like the transition from HIV to AIDS status.
- Client expectations can pose individual barriers, e.g., clients may expect services that were offered early in the epidemic to ease life for a terminally ill population before treatments became available and the emphasis of services changed. At the same time, disenfranchised populations may underestimate the services available for them.

I. Continuum of Care:

- Mr. Vincent-Jones said the Continuum of Care focuses on "Where Do We Need to Go?" The CCP enacts the Commission's mission of meeting County PLWH/A needs as informed by the Commission's planning values, chosen each year in the priority- and allocation-setting process. These are the paradigms, or world view, of equity, nuanced inclusiveness, and utilitarianism; and operating values that guide planning and decision-making of access, efficiency, quality, and representation. Compatible shared values of high quality services, collaboration, service effectiveness, and cost effectiveness were developed through SPN forums with providers and consumers.

- The first Continuum of Care was adopted in 2002 and revised in 2005. Both were centered on primary health services with supportive services and then quality of life services wrapped around them.
- The new Continuum of Care goes beyond services alone to link the desired impact on the population, health outcomes (effects), health indicators (measurements), the population-flow structure to track clients through the system of care, systems mapping to identify process and structural indicators, and interventions (services). Common terminology was also developed in collaboration with OAPP to ensure meanings remained constant among stakeholders.
- Core medical services remain central, but the new Continuum also represents the contribution of non-Ryan White-funded services with the approach continued for support services. Although not funded by Ryan White, prevention, community support, and inpatient services are represented for their roles in an integrated continuum of care. The Continuum was designed to represent the care/treatment system of care, but also to be open to collaboration with the prevention system.
- Services are broken into seven clusters to better represent their position along the Continuum: residential, barriers, counseling/education, access, coordination, primary health, and medical.
- The Population Flow Structure represents the movement of people from not at risk of HIV through those adherent to care. The effect of interventions along the Continuum appears in the ebb and flow of populations along the structure. This structure can eventually be computerized to reflect actual population movement.
- Systems mapping reflects how providing resources like funding to various services impacts care, e.g., increasing medical case management increases medical care coordination, which then increases the quality of the care plan, which improves the clinical care plan that helps patients adhere to care. The effect of decreases is mapped the same way.
- The structural and process indicators are characteristics of the system that reflect whether services are being offered in a quality, effective manner. This could be computerized to reflect changes. Meanwhile, though indicators have previously been identified, this more systematic approach ensures all pertinent indicators are mapped. Indicators are grouped into five pools: level of health care support, capacity of health care system, level of challenges/barriers to care, level of social/community support, lifestyle management. This permits selecting an indicator needed for a specific purpose like service effectiveness while representing all of them.
- Mr. Butler felt the Continuum was too complex to explain. Mr. Vincent-Jones replied that, while this is the entire continuum, pieces can be lifted out to explain various aspects of the continuum as needed, and that a simpler version of the continuum can be presented broadly.
- Health outcomes selected by the Commission are: health status, quality of life, and self-sufficiency/independent living. The health indicators measure the degree to which outcomes are being achieved and their affect on the entire population.
- This new Continuum goes beyond describing the system of care to exploring how it works, so that problem areas can be identified and addressed. The CCP will also discuss how it links with the Statewide Coordinated Statement of Need (SCSN), now being finalized. More detailed SCSN discussions with OA have been deferred due to the state budget crisis.
- Dr. Younai asked how primary versus secondary drivers will be weighted. Mr. Vincent-Jones said these indicators were the first listing of potential primary drivers. Discrimination will develop as baselines are established through data.
- The Commission has a standard for counseling/testing in the care setting as Ryan White allows funding for it, although the Commission has not allocated funds for. The Commission hopes to collaborate with the PPC on broader prevention areas.
- The CCP reflects a federal shift from "Emergency Act" to an urgent one as reflected in "Treatment Modernization Act."
- ➲ It was agreed to address federal linkages where possible though indicators for their measurements lack definition.

J. Goals and Objectives:

- Mr. Goodman presented on the CCP goals and objectives in: health outcomes, service delivery, responsiveness, unmet need, service coordination, collaboration, quality of care, service effectiveness, cost efficiency, leadership development, information technology, and reducing barriers.
- While there are three-year objectives, it is important to have goals for each year with responsible parties and tangible indicators that can be used to measure outcomes that impact patients and the system of care.
- Many indicators have been identified while others are being developed. Indicators may vary from a specific number or percentage of patients to accomplishing a set activity. For example, the responsiveness objective includes "adversity sectors" goals to develop criteria to identify "adversity sectors" in 2009, identify "adversity sectors" in 2010, and outline needed scopes and services for "adversity sectors" to improve health outcomes in 2011.
- Mr. Goodman noted that HRSA appreciated that the CCP was designed to be challenging even if all goals and objectives might not be fully achieved by 2011.
- Mr. Land asked if goals and objectives would be related to the local, state, and federal work of the Commission's committees. Mr. Vincent-Jones replied the CCP was for the entire EMA, so the narrative reflects broad responsibilities for the Commission, OAPP, and the County. Each stakeholder will develop its own detailed plan for meeting its responsibilities as the Commission does in its Work Plan.

- Ms. León expressed concern about using the Consumer Caucus as the primary consumer voice. She felt it could be exclusionary. Mr. Vincent-Jones noted that "primary" does note mean "sole" voice, in an effort to express its goal of engaging more consumers in Commission discussions countywide. Ms. Watt noted the CCP also discussed the SPA-based CABs. Mr. Johnson added the Commission is designed to be representative, not a sole voice.
- ➲ It was agreed to review the language on the Consumer Caucus objective and goals to better express its role in facilitation.

K. How Will We Monitor Our Progress?: Mr. Vincent-Jones reported this section will be devoted to quality management, service effectiveness, and development of indicators. OAPP, led by Mary Orticke, is the primary party for this section. Ms. Orticke had to leave the country for a family emergency so it had been agreed to include the remaining section for the December meeting.

L. Conclusion/Wrap-Up:

- Mr. Vincent-Jones encouraged public comments until November 30th, especially regarding goals and objectives. Comments should be submitted to him or Ms. Pinney. Written comments were easiest to review though all were welcome. Editing has not been completed, so he recommended not spending time on it.
- A revised version will be presented to the Commission in December as the CCP must be submitted to HRSA by December 31st. Dr. Green noted revisions can be sent to HRSA after submission. Mr. Vincent-Jones expressed the goal of submitting as complete a CCP initially as possible. He added that the Commission was also moving toward publication.
- ➲ It was agreed to open the revised CCP for one additional public comment period following additional work in December or January with an emphasis on reviewing newly written sections and minor revisions.

14. ANNOUNCEMENTS: Mr. Goodman noted the Priorities and Planning (P&P) Committee November and December meetings were combined into one on December 2nd at 1:30 pm. The CCP would be discussed. All were welcome to attend.

15. ADJOURNMENT: Ms. Bailey adjourned the meeting at 4:05 pm.

A. Roll Call (Present): Bailey, Ballesteros, Bongiorno, Braswell, Chavez, Chud, Daar, Giugni, Goodman, Granai, Johnson, Kochems, Land, Liso, Negrete, Nolledo, Palmeros, Sanchez, Sotomayor, Watt, Younai.

MOTION AND VOTING SUMMARY

MOTION #1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2: Nominate Robert Butler to the SPA #8 Consumer seat and forward to the Board of Supervisors for appointment to the Commission.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3: Ratify the Executive Committee decision to allocate Part A funds, as necessary, to pay for Medicare Part B premiums through Year 18.	***Passed by Consensus***	**MOTION PASSED**